

THE CITY OF SEATTLE : Aexcel® Plus Open Choice® - Most City Preventive

Coverage for: Individual + Family | Plan Type: PPO

Coverage Period: 01/01/2021-12/31/2021



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <u>www.HealthReformPlanSBC.com</u> or by calling 1-800-370-4526. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In- <u>Network</u> : Individual \$100 / Family \$300. Out- of-Network: Individual \$450 / Family \$1,350.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Emergency care & inpatient hospital services; plus in-network office visits, prescription drugs & preventive care are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: Individual \$2,000 / Family \$4,000. Out-of-Network: Individual \$3,000 / Family \$6,000. Prescription drugs: Individual \$1,200 / Family \$3,600.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out–of–pocket limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See ID card for phone number to call for a list of Aexcel designated <u>providers</u> .	You pay the least if you use a <u>provider</u> in Aexcel Designated. You pay more if you use a <u>provider</u> in In- <u>Network</u> or Aexcel Non-Designated. You will pay the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

	What You Will Pay					
Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider</u> 's office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; 10% <u>coinsurance</u> for all other services	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; 10% <u>coinsurance</u> for all other services	\$15 copay/visit, deductible doesn't apply; 20% coinsurance for all other services	40% <u>coinsurance</u>	None
	Preventive care /screening /immunization	No charge	No charge	No charge	Not covered, except 40% coinsurance for mammograms & gynecological exams	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Not applicable	10% <u>coinsurance</u>	Not applicable	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	Not applicable	10% <u>coinsurance</u>	Not applicable	40% coinsurance	None

			What You	ı Will Pay		
Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs	Generic drugs	Not applicable	30% coinsurance with minimum & maximum/ prescription, deductible doesn't apply: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	
to treat your illness or condition  More information about prescription drug coverage is available at www.aetnapharmac y.com/standard	Preferred brand drugs	Not applicable	40% coinsurance with minimum & maximum/ prescription, deductible doesn't apply: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Non-preferred brand drugs	Not applicable	40% coinsurance with minimum & maximum/ prescription, deductible doesn't apply: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	

		What You Will Pay				
Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Specialty drugs	Not applicable	Applicable cost as noted above for generic or brand drugs	Not applicable	Not covered	Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	10% coinsurance	Not applicable	40% coinsurance	None
If you need immediate medical attention	Physician/surgeon fees  Emergency room care	10% <u>coinsurance</u> Not applicable	10% coinsurance 10% coinsurance after \$150 copay/ visit, deductible doesn't apply	20% coinsurance  Not applicable	40% coinsurance 10% coinsurance after \$150 copay/ visit, deductible doesn't apply	None 40% coinsurance after \$150 copay/visit, deductible doesn't apply for non-emergency use.
	Emergency medical transportation	Not applicable	10% coinsurance	Not applicable	10% coinsurance	Non-emergency transport: not covered, except if pre- authorized.
	<u>Urgent care</u>	Not applicable	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay/</u> stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay/</u> stay, <u>deductible</u> doesn't apply	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office: \$15 copay/visit, deductible doesn't apply: other outpatient services: no charge	Not applicable	Office & other outpatient services: 40% coinsurance	None

		What You Will Pay					
Common Me Event		Services You May Need	Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Inpatient services	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay</u> / stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> / stay, <u>deductible</u> doesn't apply	Pre-authorization required for out-of-network care.
		Office visits	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	Cost sharing does not apply for preventive services.
		Childbirth/delivery professional services	10% coinsurance	10% coinsurance	20% <u>coinsurance</u>	40% coinsurance	Maternity care may include tests and services
If you are pre	egnant	Childbirth/delivery facility services	Not applicable	10% coinsurance after \$200 copay/ stay, deductible doesn't apply; copay waived for newborn hospital expenses	Not applicable	40% coinsurance after \$200 copay/ stay, deductible doesn't apply; copay waived for newborn hospital expenses	described elsewhere in the SBC (i.e. ultrasound.) If your plan is subject to health care reform law, there will be no charge for in-network preventive prenatal care. Pre-authorization required for out-of-network care may apply.
		Home health care	Not applicable	10% coinsurance	Not applicable	40% coinsurance	130 visits/calendar year.  Pre-authorization required for out-of-network care.
If you need h	•	Rehabilitation services	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% coinsurance	None
recovering or have other special health needs	Habilitation services	Not applicable	\$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	40% coinsurance	None	
		Skilled nursing care	Not applicable	10% <u>coinsurance</u> after \$200 <u>copay</u> / stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay/</u> stay, <u>deductible</u> doesn't apply	120 days/calendar year.  Pre-authorization required for out-of-network care.

	What You Will Pay					
Common Medical Event	Services You May Need	Aexcel Designated Provider (You will pay the least)	In-Network Provider (You will pay more)	Aexcel Non- Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	Not applicable	10% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	Limited to 1 <u>durable</u> <u>medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	Not applicable	10% <u>coinsurance</u>	Not applicable	40% coinsurance	Pre-authorization required for out-of-network care.
If your shild poods	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
delital of eye care	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	Not covered.

### **Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)

- Long-term care
- Routine eye care (Adult & Child)

- Routine foot care
- Weight loss programs Except for required <u>preventive</u> services.

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits/calendar year.
- Bariatric surgery Limited to Institutes of Quality contracted facility only.
- Chiropractic care 20 visits/calendar year.
- Hearing aids \$1,000 maximum per ear/36 months.
- Infertility treatment For more information & exceptions, see policy document provided by your employer.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

# **Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

• For more information on your rights to continue coverage, contact the <u>plan</u> at 1-800-370-4526.

- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church <u>plan</u>, church <u>plans</u> are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

## **Your Grievance and Appeals Rights:**

There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <a href="http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html">http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</a>.

## Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

## Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

# **About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

# Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
Copayments	\$10
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,270

# Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$10
Specialist copayment	\$1
■ Hospital (facility) coinsurance	10%
Other coinsurance	10%

### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$820

# **Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$100
Specialist copayment	\$15
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800				
In this example, Mia would pay:					
Cost Sharing					
<u>Deductibles</u>	\$100				
<u>Copayments</u>	\$80				
<u>Coinsurance</u>	\$200				
What isn't covered					
Limits or exclusions	\$0				
The total Mia would pay is	\$380				

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

## **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

## **Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

## **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),

1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

### TTY: 711

## **Language Assistance:**

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian - Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.

Amharic - ለቋንቋ እንዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526 الرجاء الاتصال على الرقم المجاني

Armenian - Lեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով։

Bahasa Indonesia - Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.

Bantu-Kirundi - Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa

Bengali-Bangala - বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।

Bisayan-Visayan - Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.

Burmese - ငွေကုန်ကျစံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။

Catalan - Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.

Chamorro - Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.

Chinese - 欲取得繁體中文語言協助, 請撥打 1-800-370-4526, 無需付費。

Choctaw - (Chahta) anumpa y<u>a</u> apela a chi I p<u>a</u>ya hinla 1-800-370-4526.

Cushite - Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.

Dutch - Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.

French - Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.

French Creole - Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.

German - Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.

Greek - Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.

Gujarati - ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

Hawaiian - No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei.

Hindi - हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.

lbo - Maka enyemaka asusu na Igbo kpoo 1-800-370-4526 na akwughi ugwo o bula

llocano - Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.

Italian - Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.

Japanese - 日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。

Karen - လာတာမ်ာစားတာကတိုးကျိုဘဲအင်္ဂါ ကျိုာ် 🛱 800-370-4526 လာတအို ၁ ဒီးတာလာဘ်ဘူဉ်လာဘ်စားဘဉ်

Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.

Kru-Bassa - Be´m`ké qbo-kpá-kpá dyé pidyi dé Bašsoó-wuduun wee, dá 1-800-370-4526

برای راهنمایی به زبان فارسی با شماره 4526-370-370 به خورایی پهیوهندی بکهن.

Laotian - ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລນາໂທຫາ 800-370-4526 ໂດຍບໍ່ເສຍຄ່າໂທ.

Marathi - कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.

Marshallese - Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.

Micronesian-

Pohnpeyan - Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.

Mon-Khmer, សម្រាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ទទទៅកាន់លខេ 1-800-370-4526 ដំោយឥតគិតថ្លប់។

Cambodian -

Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526

Nepali - (नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।

Nilotic-Dinka - Tën kuoony ë thok ë Thuonjän col 1-800-370-4526 kecin ayöc.

Norwegian - For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.

Panjabi - ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ।

Pennsylvania Dutch - Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.

برای راهنمایی به زبان فارسی با شماره 4526-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Persian -

Polish - Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.

Portuguese - Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.

Romanian - Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - אבר אינ שובר שמון מאר שלב א שבאו מאר שלבע הר שמון זהר זאל,שם ב-1-800-370-4526 משל ב- אינ שובר אלו זה של ב-1-800-370-4526 משל ב- אינ שובר אלו זה של ב-1-800-370-4526 משל ב-1-800-370-4526 משל

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్పు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 . پر بات کریں۔

Vietnamese - Đê 'được hố 'trơ ngôn ngư băng (ngôn ngư), hấy gọi miến phi 'đên số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlowo nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.